GEBA
Government Employees' Benefit Association

1362 Mellon Road, #100
Hanover, MD 21076
Fax: (410) 846-6420
Email: geba@geba.com
Phone: (410) 657-8060

Member Number
(if unknown, leave blank)

Retirement/Resignation Form - Insurance

General Information:

First Name | MI | Last Name | Social Security Number XXX-XX- | Gender: ◯ Male ◯ Female

Marital Status: ◯ Married ◯ Domestic Partner ◯ Divorced ◯ Widow/Widower ◯ Single ◯ Separated

Date of Birth (mm/dd/yyyy) | Email Address

Address Line 1 | Address Line 2

City | State | Zip Code

Home Phone Number | Cell Phone Number | Office Phone Number

By providing your email address to us, you expressly consent to receive emails from us. We may use email to communicate with you, to send information that you have registered, or to send information about other products or services developed or provided by us, provided that we will not give your email address to another party to promote their products or services directly to you.

I am: ◯ Retiring Date:

◯ Resigning Date:

Retirement/Resignation:

◯ CONTINUE MY COVERAGE: You may keep your Group Term Life, Emergency Travel Plan, Dental Insurance, and Vision Insurance. Please select your payment frequency from the table below.

Plan	Monthly	Quarterly	Semi-Annual	Annual
Group Term Life	◯ Auto-Debit	◯ Auto-Debit	◯ Auto-Debit	◯ Auto-Debit
Emergency Travel Plan	◯ Auto-Debit	◯ Auto-Debit	◯ Auto-Debit	◯ Auto-Debit
Dental Insurance	◯ Auto-Debit	◯ Auto-Debit	◯ Auto-Debit	◯ Auto-Debit
Vision Insurance	◯ Auto-Debit	◯ Auto-Debit	◯ Auto-Debit	◯ Auto-Debit

◯ CANCEL MY COVERAGE: I wish to cancel the following plans after my last payroll deduction:

☐ Group Term Life Insurance ☐ Dental Insurance ☐ Emergency Travel Plan

☐ Group Long Term Disability ☐ Vision Insurance ☐ Professional Liability Insurance

I UNDERSTAND that my coverage for Group Long Term Disability and Professional Liability Insurance will terminate due to my departure from the agency after my last payroll deduction or at the end of the month in which I resign/retire and will be refunded the unused portion of my paid premiums.

◯ BECOMING A CONTRACTOR: I am leaving the agency, but returning as a contractor assigned to the agency and I wish to continue my Group Long Term Disability coverage paying via auto-debit.

Contractor Name:

◯ SWITCHING FEDERAL AGENCIES: I've been hired at another federal agency and I wish to continue my Group Long Term Disability and/or Professional Liability Insurance paying via auto-debit.

New Agency:

Please Sign Below:

By signing below, I hereby authorize GEBA to change my plan(s) according to the information I have provided on this form. I certify that the above information is correct.

Signature: _____ Date:

Automatic Debit Payment Information:

☐ Checking Account (enclose a copy or voided check) ☐ Savings Account

Bank Name: _____

Bank Routing Number: _____ Your Account #: _____

Your automatic debit payment may be prorated based on effective date of the change and the frequency you selected.

For existing members using automatic debit: If the provided banking information above differs from what GEBA currently has on file, we will update all automatic debits to match the information entered on this form.

Check with your bank to determine if additional charges for a debit will apply and ask how it will describe automatic debits on your bank statement. If you plan to have payments deducted from a savings account, please check with your bank to see if there are limitations (if any) on recurring debits.

I hereby authorize Government Employees' Benefit Association, Inc. (GEBA) to debit my checking/savings account according to the published schedule. I understand that GEBA reserves the right, upon written notification, to terminate my participation in this payment option. If an automatic debit is returned for any reason including insufficient funds, closed or unauthorized account, GEBA will not be able to process payment. I understand that I may be subject to a $20 charge if payment is rejected, reversed, or refused by my financial institution. I may cancel participation in the GEBA Automatic Debit service with written notice 10 days prior to the premium due date.

Please Sign Below:

By signing below, I agree to pay full year of premium payments. I understand that if I cancel coverage before paying for all year of premium payments, the balance will be due at the time of cancellation. I certify that the above information is correct.

Signature: _____ Date: _____